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ABSTRACT

This paper primarily considers the effects of parental and sibling deaths on preadolescent children, including the relationship of child rearing styles to the process of mourning. Through a review of the literature and an integration of several psychological factors, the author shows that familial death places children at risk. However, she emphasizes that the heightened possibility of developmental disturbances does not make their occurrence inevitable. This paper also explores research findings that substantiate emotional health and growth as a corollary of familial death. (Author)

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THE RELATIONSHIP BETWEEN CHILD REARING STYLES AND THE EFFECTS OF FAMILIAL DEATH ON PRE-ADOLESCENT CHILDREN

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All births and deaths are recorded in the consciousness of others. I am particularly interested in the impact that death creates in the consciousness of children. This paper will primarily consider the effects of parental and sibling deaths on pre-adolescent children, including the relationship of child rearing styles to the process of mourning. Through a review of the literature and an integration of several psychological factors, I will show that familial death places children at risk; however, the heightened possibility of developmental disturbances does not make their occurrence inevitable. This paper will also explore research findings that substantiate emotional health and growth as a corollary of familial death.

DEVELOPMENTAL REACTIONS TO DEATH:

Children are in an "at risk" position following a familial death, because of the pervasive dimensions of this situation. But, in order to appreciate the many facets and implications of familial death on a child, it is necessary to understand the reactions children have to death as a result of their developmental stages. Many correlations have been made to childrens' death reactions and the child's age (Schilder and Wechsler, 1934; Nagy, 1948; Salfer, 1964; Morrissey, 1964; Rochlin, 1967; Gartley and Berasconi, 1967).

Schilder and Wechsler (1934) found that children dealt with death in a

matter of fact, realistic way. Young children in their study emphasized the immobility of the dead and, consequently, viewed death as a deprivation and didn't themselves want to die. The younger children saw death as a reversible fact. The five to eight year olds in this study were quite ready to believe in the death of others, particularly violent deaths, and expressed a willingness to kill others, although this was often only revealed in play situations. The authors attributed a child's willingness to kill others to the fact that young children have no objection to depriving others and, thus, a lack of revulsion against the idea of killing. These children also lack a sense of the permanence and irreversibility of death and may, therefore, see killing as no more serious than hitting. But, because a child fears punishment, she or he may have a professed morality which is quite utilitarian. Schilder and Wechsler found a need in their young subjects to pass moral judgment on every person and picture in the questionnaire and pictorial components of their research design, but they found that religious morality was relatively rare. For most of these children, death was not viewed as a natural end to life, but rather as a result of the hostility and punishment of others, including God. A killing ghost was seen as a natural part of the world and God was seen as a magician. Therefore, anything that was unexpected and unusual was endowed by these children with potential death powers - including ghosts and corpses. All of the children in this study were between the ages of

five and eight.

Some of Schilder and Wechsler's results were refined by Nagy's (1948) research findings. She formulized a chronological demarcation of the stages in childrens' views of death, dividing them into three stages. She found that Stage One children (three to five year olds) saw death as a departure, or sleep, that was a temporary condition. Life and consciousness were attributed to the dead by these young children who felt that the dead could feel, grow and think. To Stage One children, the dead were essentially alive in the grave. The immobility in the coffin was viewed as a consequence of exterior, confining circumstances. In short, this younger aged group saw death as living under different, changed circumstances.

The Stage Two children of Nagy's study (ages five to nine) viewed death in one of two ways. One way was to imagine death as a separate person and personify it. Many of these children talked about a skeleton man or a death man. The other group of children in Stage Two identified the concept of death with the dead and were likely to speak of ghosts. The Stage Two children viewed death as outside of themselves and as a phenomena that was not universal.

The children in Stage Three were nine years of age or older. It is only at this age that Nagy found children believing that death was the cessation of corporal life and that it was universal and inevitable.

Gartley and Bernasconi (1967) did a study of the death concepts of Roman Catholic children between the ages of five and fourteen and reported the findings in one year increments beginning at age five and a half. They found that five year olds associated death with living in a coffin. Although they didn't know what death was, these children didn't think it would hurt to die. They saw death as very remote and something that could not happen to them. This allowed them to accept death very matter of factly. The six and seven year olds in this study thought that people died at the end of the world and still saw it as remote and happening only to others. The majority of six and seven year olds thought they couldn't play in heaven, because they viewed it as a restrictive place where God replaced their parents. The seven and eight year olds began to verbalize a concept of heaven and hell and, for the first time, the child of this age recognized death as a personal possibility. Killing to this age child was not seen as permissible. The eight and nine year olds began to verbalize a distinction between body and soul and recognized that their own death could happen at any time. This age also had a more objective view of pain in death. The nine and ten year olds shared most of the perceptions of their year younger peers, although there was a greater emphasis on violent deaths at this time. From the age of ten on, these children viewed the death sequence as involving death and burial, with the soul going to heaven, hell, or purgatory. There was a recognition of body decay

at this age. From the age of ten and a half, these children were aware that they could die at any age, but they recognized that the probability was very slight for them.

Gartly and Bernasconi's findings differed from Schilder and Wechsler's (1934) in that the Catholic children all believed in the finality rather than the reversability of death. In addition, they all believed in their own death, even if it was thought to be far in the future. Unlike Nagy's (1948) study, there was no evidence of personification of death.

Relatively little has been studied about very young children's concepts of death, but there is disagreement among those who have. Gesell (1946) and Anthony (1940) state that in the first two years of life there is no understanding of death. But Maurer (1966) has explored the possible relationship between particular experiences and behaviors and a young child's relationship to a state of non-being. Maurer suggests that the infant's alterations between sleep and wakefulness is a basis for the child's experimentation with contrasting states of being. Citing the child's game of peek-a-boo (from the Old English, meaning "Alive or Dead?"), Maurer discusses games of disappearance and return as mini experiments with death and non-being.

Rochlin (1967) studied a sample of three, four and five year olds who were

the offspring of urban, well educated parents with no church affiliations. He found that children of this age had definite death fears that they tried to master in part by repetitive play, such as continual car wrecks and airplane accidents with their toys. As a defense mechanism against death, he found children re-defining death as a liberation from all of life's restrictions. Powers previously limited in life were extended without boundaries to the dead by the children in this sample.

The causal elements of death cited in Rochlin's sample were the result of strife, hostility, retaliation, and a defiance of authority. There was an element of morality cited by these children in their belief that the bad die before the good and that the good can be rewarded by a return from the dead.

Rochlin suggests that a reaction to the discovery of death leads to the initiation of an active civilizaing process in both children and adults. Both age groups tend to imitate their superiors or those who have power and influence over their lives.

Rochlin observes that it is not remarkable that children eventually arrive at the adults' view of death, but that adults tenaciously hold onto children's views of death and readily revert to them.

What the above theorists and others are, in effect, saying is that the

development of the intellectual concept of death is multi-dimensional and includes many phases. Beginning with the young child's interest in death, she or he must learn the difference between dead and alive. At later stages the child will include verbal symbols, an understanding of death causes, cultural customs regarding disposal of the corpse, a realization of the inevitability of death and, finally, the ability to understand death in abstract terms incorporating philosophical and religious concepts. The development of these concepts have been found to be age-related and roughly sequential.

EFFECTS OF FAMIAL DEATH ON CHILDREN:

The preceding capsule explanation of children's developmental concepts of death is a pre-requisite to an understanding of the dimensions of the situation that might produce developmental disturbances or psycho-pathology in children. The child's experience of a death anxiety is recorded by many and is explained as the antecedent to many developmental disturbances (Natterson and Knudson, 1960; Alexander and Adlerstein, 1958; Kavanaugh, 1972; Morrissey, 1963; Schowalter, 1970).

The existence of a death anxiety in boys aged five to sixteen years was shown by the work of Alexander and Adlerstein (1958). They measured the affective responses to "death" words (buried, kill, death) in a list of twenty-seven spelling words. Measures of response times and galvanic skin responses (GSR) were recorded as indicators of affect. They found an increased emotional

involvement with the death words on both response measures throughout their sample.

There is nothing peculiar to children about these findings, but the authors note that some periods of childhood are subjected to greater increases in psychological stress. It is at such times, they feel, that a decrease in ego stability is likely to be reflected in an increase in affective responses to death.

A death anxiety is also observed in children who are themselves dieing. (Morrissey, 1963; Natterson and Knudson, 1960; Schowalter, 1970). In Morrissey's (1963) study, the children's anxiety centered on separation from their parents and the significance of their illness. They expressed their anxiety in one of four ways: verbally, behaviorally, physiologically and symbolically. Behavioral manifestations of axiety were: increased hyperactivity, regressive play and withdrawal from peers. Physiological expressions of anxiety were associated with nausea, poor appetite, a loss of energy and depression (controls were established for drugs and medication). Anxiety was symbolically expressed through play. Morrissey notes that all but two of the children in his sample displayed one or more of the above forms of anxiety. Two of the children he interviewed were spontaneious and positive about their futures and they were the only two to survive. It is these findings that allow him to suggest a positive correlation between a child's verbalizations and his or her prognosis.

In another study by Morrissey (1964) different types of anxiety were reported for leukemic children of different ages. A separation anxiety was experienced by the younger children, usually under the age of five. The separation from family and friends was the prime issue around which the separation anxiety was exp essed. A castration, or mutilation, anxiety was most often experienced by children between the ages of six and nine. With this anxiety, the children were most concerned about the medical procedures being performed (such as transfusions and bone marrow aspirations) and the concomitant pain. Beginning at the age of nine, children were experiencing a death anxiety that was centered on issued of one's own identity and existence.

Morrissey (1964) found that the expression of the various anxieties was apt to be through symbolization, such as drawing, painting and play. The younger the child, the more likely she or he is to use subtle, symbolic expressions of anxiety. He found older boys to be more likely to act out and older girls more likely to be depressed.

Natterson and Knudson (1960) found substantially the same age related anxieties as Morrissey. The children in their study were all fatally ill and subjected to the same three conditions: separation from their mothers, traumatic hospital proc dures, and the death of other children. Under the age of five,

they found children most concerned about the separation. Children aged five to ten were most anxious about hospital procedures, while those over the age of ten were most affected by an awareness of death. When other children died, Natterson and Knudson observed that few survivors talked about them, although many were depressed and withdrawn after being informed of a peer's death.

Another age related study of children's anxieties concerning their own deaths was undertaken by Schowalt r (1970). The youngest children in his study were infants and toddlers under the age of three. He found that the younger the children, the more likely were their affective responses to be influenced by those around them. He posits a separation anxiety at this age based on the child's realization that she or he is not omnipotent, but is, in fact, completely dependent on his or her parents. This realization gives rise to a fear of abandonment. Accompanying this anxiety is an anger towards the parents for not ensuring protection against the illness. If the child's anger is greater than his or her fear, Schowalter predicts rebellious behavior on the part of the child. If, however, the fear is more heightened in the child, he feels that compliancy can be expected from the child.

Separation anxiety is not the only dimension of familial death that might cause developmental disturbance in children. The impact of guilt on the lives of bereaved children has been observed by many. (Arthur & Kemme, 1964;

Cain and Fast, 1964; Schowalter, 1970; Keeler, 1954; Weston and Irwin, 1963; Cobb, 1956).

Cain and Fast (1964) speak of guilt reactions and their vicissitudes among children's disturbed reactions to the death of a sibling. They note trembling, crying and great sadness as manifestations of guilt often occurring years after the sibling's death. These findings seem to correlate with Frankl's (1959) discussions of a "Survival Syndrome", in which the living feel that either they should have died too, or instead, therefore, they have no right to enjoy any pleasures in their life.

In another study of sibling death, Weston and Irwin (1963) discuss a child's guilt resulting from the fulfillment of a sibling death wish. When the sibling dies, a causal relationship between the death wish and the event is assumed and guilt is induced. This supposed omnipotence is a further source of anxiety when a child internalizes great personal destructive abilities. The constellation is further crystallized with the addition of anticipatory punishment or talion fantasies.

Cain and Fast (1964) found many different expressions of guilt among the children in their study, including acting out, depressive withdrawal, punishment seeking, accident prone behavior, an exhibitionistic use of guilt and grief, and constant provocative testing.

The child's actual involvement in a sibling's death proves additional ramifications. Cain and Fast (1963) discuss a family pattern of self blaming and blaming of other family members followed by a defensive attempt to not blame each other. During such defensive times, outside agents such as hospitals, doctors, neighbors, or car drivers were often blamed. While this homeostatic attempting behaviour worked for many in their study, about fifteen per cent experienced severe familial disruptions as a result, e. i. divorce, desertion and patricide.

A child's sense of guilt was further intensified in the Cain-Fast study by two additional family actions. One was the parent's refusal to allow a child to discuss his involvement in his or her sibling's death. This happened in approximately one-third of the cases in which a child had been significantly involved in the death. The parents accomplished this by interrupting the child, giving blanket reassurances and/or labeling the incident an unavoidable accident. The second family action that intensified a child's guilt was the parent's attitudes of blame that were covertly or explicitly acknowledged. A combination of hostility and minimum love were used to propagate the child's guilt feelings. When the child's guilt was extremely intense, she or he often expressed a fear of losing control of anger and of being a potential killer. In one-quarter of the cases in this study, guilt was imposed on the child by the parent because of the paucity or inadequacy of expressed grief on the part of the child.

In Schowalter's (1970) study of fatally ill children, he found children under the age of ten expressing a strong fe ling of responsibility for their own illness which resulted in a sense of guilt. He found that children either accepted that guilt or projected it onto parents and hospital staff. If the child accepted the guilt, he found the child likely to be passive and withdrawn. If the child projected the guilt, Schowalter found the child likely to be angry and rebellious. It was his further observation that a child who is angry and rebellious (projects his guilt) is more likely to respond positively to treatment than a child who acquiesces.

Keeler (1954) observed guilt as one reaction children experienced in relation to their parents' death, but not the most pervassive one. In his study, guilt was the seventh (of eleven) most common reaction. He explains guilt as the result of the fulfillment of an Oedipal wish.

DEVELOPMENTAL DISTURBANCES PRECIPITATED BY FAMILIAL DEATH:

A variety of different symptoms including personality disorders, neuroses and intereferences in functioning have been cited as a result of childhood bereavement. (Arthur and Kemme, 1964; Cobb, 1956; Cain and Fast, 1964; Keeler, 1954; Rochlin, 1967, Yudkin, 1967).

In Keeler's (1954) study of parental death, he found symptomatology of: depression, delinquent behavior, sucidal attempts and preoccupation, anxiety,

aggression, aggravation of pre-existing schizophrenic tendencies and autonomic disturbances such as vomiting.

Arthur and Kemme (1964) discuss a high incidence of children's intellectual problems as a result of the death of a parent. They specifically discussed difficulties in abstract thinking as related to concepts of finality and casuality to be disturbed by the loss of a parent. These authors make the further observation that feelings of inadequacy, insecurity, worthlessness and emptiness experienced by many children in their sample may seriously impair future personality development. A similar distortion in the cognitive concepts of time and causality are noted by Cain and Fast (1964).

An over identification with a deceased parent has been shown to result in acting out behavior, excessive fantasy and hysterical conversion reactions (Keeler, 1954). Over identification with a deceased sibling has been linked to a sympton identification on the part of the living sibling. Such symptoms as asthmatic attack, hysterical pains, and motor paralysis have been observed in the immediate, prolonged and anniversary identifications of siblings (Cain and Fast, 1964). The acquisition of both characteristics and hobbies of a dead sibling have been noted in behaviours of remaining siblings (Cobb, 1956).

Distorted concepts of death, illness, doctors and religion have been observed. (Cobb, 1956; Cain, 1964). Children whose sibling has died from an illness are more likely to show increased concern about their own health and illness. Some children have misconceptions about minor illnesses resulting in

The pathological distortions to death that have been mentioned by the various researchers above fall into the following five domains: affective, cognitive, super-ego functions, belief systems, and object relationships. Various factors are involved in the determination of which dysfunctions are manifested in specific children. Many theorists agree that it is a constellation of factors which determine how any specific child will be affected. Among these factors are: child's age; relationship to the deceased; circumstances of the death; the child's past experiences with death; the child's general knowledge of death; the child's religious training and the child's cognitive maturity (Keeler, 1954). Other important variables include: the child's involvement in the death; the child's pre-existing relationship with the deceased; the parent's reaction and handling of the death; the changes in the family dynamics; the reaction of the community; and other stresses to which the child or family might be subjected (Cain, 1964).

Also to be considered, when assessing the extent of developmental disturbances, are the long time effects of childhood bereavement. Significant and positive correlations have been drawn between early childhood loss and adult pathology (Glueck and Glueck, 1934), Barry, 1949; Hilgard, Newman and Fish, 1971; Furman, 1974).

Barry (1949) looked at the significance of maternal death in a child's life before the age of eight and the later incidence of adult psychosis. Between his

psychotic and normal samples, he found that the incidence was three times as great for the adult psychotic to have experienced early childhood maternal death than for the adult normal population. He further postulated that the early childhood death of a moth was much more likelty to be related to adult psychosis than the death of a father at the same age. His findings showed approximately an equal incidence of paternal death in the early years of both his psychotic and normal subjects.

Hiigard and Newman (1959) spoke of both the positive and pathological adult ego following childhood bereavement. One example of social pathology following parential loss is a continued dependency of the surviving parent that is transferred to the child. The surviving parent might look to the child for emotional support and sometimes continues this dependency into the adult years of the child. In its extreme form, this dependency might make it impossible for the child to work through a normal separation from the parent. Several men in this study report feeling that their mothers had made them substitute husbands after their father's deaths. Anniversary syndromes were also reported in this study as manifestations of social pathology when they were experienced with irrational intensity. Obsessions with the thought of dying at the same age as a parent could be such a dramatic example.

FAMILY DYNAMICS AND CHILD BEARING STYLES

The myriad expressions of pathological disturbance following childhoild bereavement range from sadness to suicide (Zeligs, 1967). But the impact of familial death reverberates throughout the family. As each member is affected, she or he in turn affects other family members and a network of ricocheted reactions is set up. Thus, each individual's reaction is also linked to the reactions of other family members, the medical staff's reaction and sometimes the feedback from the neighbors and the community. A comprehensive survey of children's reactions to familial death necessitates a more comprehensive investigation of these tangential elements.

The discussion of the child's developmental reaction to death earlier in this paper demonstrates the young child's confusion and conflict over death. In an effort to understand a parent's feelings, a young child often elicits parential grief and/or imitates the parent's grief (Weston and Irwin, 1963). Eliciting grief can be done by asking questions about the death and repeating feelings of missing the dead parent or sibling. Once this is done, the child has a model of grief to imitate. According to Weston and Irwin, the pre-school child is not intellectually or emotionally ready to handle the loss of a sibling and, therefore, the parent's grief gives the child a behavior pattern to follow.

Several studies discuss the effect of a fatally ill child on family dynamics (Weiner, 1970; Cobb, 1956). Weiner (1970) discusses four stages of parental

reaction to the knowledge that their child is dying and relates these reactions to the family structure. The first, or initial reaction, includes shock, numbness, disbelief, fainting and an inability to comprehend the medical explanation. Specifically from fathers, there is a tendency for stoicism and detachment during this stage. Guilt, anger and hostility are often expressed at this point resulting in overprotection and/or over-indulgent behavior towards the dying child. This may elicit feelings and verbalizations of favoritism on the part of other siblings in the family.

The second stage, or Interim Reaction that Weiner discusses, often involves extensive medical reading and research by the parents regarding their child's illness. Sometimes strong friendships are formed in the hospital with other parents whose children are dying. Weiner feels that parents can and should help care for their child in the hospital with such tasks as bathing, feeding and dressing during this stage. Such efforts are often thwarted by hospital personnel, however. During this stage, other children in the home often experience feelings of abandonment and feel less important than before their sibling's illness. These feelings can nuture additional feelings of guilt which might be manifested in depression, nightmares and reactive aggressive behavior. This period can be the see for future disturbances among the other children in the family.

Anticipatory grief is the third stage in Wiemer's dichotomy; however, it is most prevalent in cases in which the illness lasts four months or longer.

During this period of time, there is a gradual relinquishing of hope that appears to need a nimimum time frame. The last stage, or Terminal Reaction, is most dramatic in parents who sustained denial throughout the child's illness, or with those who had little time to prepare because of a sudden death.

Weimer's central consideration in the final outcome of the family's experience with a child's death is the nature of the marital relationship prior to and throughout the child's illness. Cobb (1956) also speaks about the marital stability as a factor in family dynamics throughout this ordeal. Cobb's experience has shown that with a marriage that was stable prior to the child's illness, the impending death often draws the parents even closer together in their common struggle. If, however, the marriage was unstable, the opposite is more likely to happen. Despite parental attempts to compensate, deleterious effects on other siblings are a common research finding.

Cobb also studied parental reactions to remissions and regressions following experimental treatment. The important variables proved to be hope and the child's freedom from pain. When both of these were present, parents reported gratitude for the extra months, days and minutes with their child that medication made possible. However, when only suffering was left, there was a general wish to prolong the child's life no longer.

Parental over-protection of remaining children is cited frequently in the literature (Cain, 1964; Weimer, 1970; Furman, 1970). Parents tend to become

restrictive of the activities of their other children. This tended to foster immaturity, fearfulness, a passive-dependency, and feelings of inadequacy in such children. Sometimes, only one remaining child in the family is singled out for this behavior, as in the only remaining daughter. In such cases a favored role is actualized or perceived by the other children.

Family dynamics can be altered greatly following a child's death. Depending on each family member's relationship to the deceased child, she or he may have lost a playmate, protector, scapegoat or buffer. Realignments in family dynamics often result (Cain, 1964).

The "mis-identification" of a remaining child can happen after a child's death. One sibling might be openly and continuously compared to the deceased such that she or he becomes a substitute for the dead child. A continuous comparison of school performance in this regard might result in vengeful school failures on the part of the remaining child (Cain, 1964).

In rare instances, a child is purposely conceived after a child's death to serve as a substitute for the dead child. (Cain, 1965). In such families, the parents' reaction to the death was often so severe and despondent they might verbalize a wish that the entire family be dead. Such parents show such an utter and continued inability to re-invest their feelings that they withdrew from friends and neighbors. Such homes generally have a funeral atmosphere with the

dead child's room conveted into a virtual shrine. When such parents decide to conceive a child, their intensive narcissistic investment in the dead child is a serious clue to impending problems. Children born into such homes were eventually molded into fearful, infantile, immature, vulnerable, home-bound children. Strong passive-dependent elements in their personalities were observed as were widespread ego restrictions (Cain, 1965). These childred often worried about their own death and were convinced that they wouldn't live into adulthood. An intense interest in cemetaries, funerals and the general paraphernalia of death were common. Such a child's life was further restricted because these parents often blamed ghe child for his or her sibling's death, even though it happened before they were born. In effect, the new child in this situation was asked to both mourn and join in the idealization of his competitor, an untenable position in which to be.

A usually ignored segment of familial death is the impact of miscarriage on children. Cain (1964) has studied children's disturbed reactions in this situation and has found the following among the disturbed reactions: nightmares; anxiety attacks; stuttering; death phobias; depressions; increased aggressions; running away; separation anxiety; hatred towards the mother; and sucide attempts. This study shows that when the child has an inaccurate concept of miscarriage, she or he may have fantasies of the fetus being killed or abandoned. The child might blame him or her self because of rival feelings toward the unborn child, or

because his or her actions (such as too much noise) caused the miscarriage. If the parents are expressing remorse, the child might further experience emotional upset because she or he might conclude that her or his existence is not enough for the parents. Many variables, including the mother's reaction and feelings about this pregnancy, and the father's reactions determine the change in family dynamics. What is demonstrated is that the possibility exists in this situation for disturbed reactions on the part of either parent or the children, and, furthermore, a change in family dynamics can be expected along with an individual reaction.

A relationship between child rearing practices and suicide is found in the sociological literature (Kardiner, 1951; Hendin, 1964). Kardiner defines a concept of "basic personality" which suggests that the child-rearing practices of any culture tend to be institutionalized and, therefore, most children in a given culture are exposed to a common core of experiences. He posits that these basic personality configurations are responsible for different suicide rates in different sub-cultures.

In a study of suicide rates in Sweden, Norway and Denmark, Hendin (1964) demonstrated a link between institutionalized child-rearing practices and suicide. In Denmark, he found that mothers tended to encourage their children to be dependent, to inhibit overt aggression and to use guilt as the principal form of

discipline. The suicide rate in Denmark is very high; however, the homicide rate is very low. Hendin draws a causal inference between the marked dependency concern of Danes and their vulnerability to depression and suicide following the termination if a relationship.

In Sweden, which also has a high suicide rate, Hendin found different child-rearing sytles. Swedish mothers tend to encourage their children to be independent and self-sufficient, while at the same time, experiencing little pleasure from caring for or playing with their children. Handin feels that this, plus Swedish children's early separation from their mothers in day care centers is responsible for much anxiety and resentment. He also notes that between the ages of five and ten, boys are outside of the home and left alone more often than girls. This allows girls more and closer contact with their mothers and more availability of a same sex role model. Hendin suggests that this is a factor in the higher suicide rate for males.

In Norway, which has a low suicide rate, Hendin found that Norwegian mothers encouraged independence in their children, but are likely to make them the center of their own emotional life. They allow children a great deal of physical freedom and freedome to express aggression verbally. The mothers do not make affection conditional upon success (as the Swedes do).

A study of Japanese culture (Iga, 1966) also demonstrates the relationship of child rearing styles to suicide. Most Japanese suicide victims exhibit

dependency, self-assertion and insecurity. The mother encourages an early and prolonged dependency on her. The child is often the mother's only outlet for unrestrained expression in a formal, authoritarian society, as well as her only outlet of self-assertion and achievement. The child is put in a position in which he (more so than she) must succeed to satisfy both his own and his mother's achievement needs. This strong dependency and intense desire for success produces a continual sense of insecurity. The child is put into a pressure cooker in a culture that views suicide as an honorable death. The relationship between child rearing styles and suicide seems very obvious here.

When speaking of the severity of disturbance, the range of impact often extends beyond the immediate family. The response of the medical staff to a child's death often has an effect on the family. Wiener (1967) has found it common for doctors to have deep-seated, ubiquitious feelings of unease about death that may even account for their original choice of medicine as a career. An unconscious need to exercise power over illness and death can play a deciding factor in a medical career choice. In such instances, a fatal illness is extremely frustrating to be involved with, and this in turn often leads to anger, resentment and guilt on the part of the physician. Wiener (1967) found that such guilt could lead to one of several reactions, all of which had an impact on the family. One was to avoid the situation by delegating much of the medical care to the house staff of the

hospital or to make rounds when the child is thought to be asleep and/or the parents not present. Avoidance of this type further isolates the family and cuts them off from possible support and counsel from their doctor. The doctor with death avoidance mechanisms may intellectualize the child's illness by stressing the symptoms and treatment instead of the child. This also serves to insulate the doctor from the family.

Nursing personnel studied by Wiener tended to show increased emotional distance from dying children in proportion to their years of nursing experience. It appears that attachmentsearly in their nursing careers resulted in painful termination when the child died and resulted in an eventual lessening of emotional involvement. This substantiates Evans (1968) advice that medical staff should not form too exclusive a relationship with a dying child. Although such practice and advice offers emotional protection for the medical staff, it adds to the isolation, confusion and loneliness of death for the family.

VARIABLES CONDUCIVE TO A NORMAL BEREAVEMENT

As has been demonstrated, children are at psychological risk when a parent or sibling dies, but emotional disturbance is not the inevitable result. There are many variables that help ensure a normal adjustment following familial death. Beginning with the way a child is told about a family member's death, the foundation can be set for a normal bereavement process. In a sibling's death,

Weston and Irwin (1963) state that a child should be told that his or her sibling, by name, has died and will not come back. At the same time, parents should share their own feelings of loss, grief, anger and disappointment whelle at the same time letting the child know that she or he is not expected to experience the same feelings.

Furman (1970) stresses the importance of giving children the repeated opportunity to talk about their feelings, especially in cases of sudden death.

Zeligs (1967) suggests the optimum preparation for death starts long before the death of a family member. She advises taking advantage of the natural deaths in the environment to establish a basic concept of death with children. Natural discussions about dead flowers, plants, animals and pets as they are observed or occur is her preferred way of introducing the idea of death. Zeligs further makes the point that the difference between sleep and death should be a part of such a discussion. While making a distinction between death and sleep, Zelig strongly advises against teaching a child the prayer, "Now I lay me down to sleep ....." which she feels adds to the confusion of the death/sleep distinction.

A child's attendance at a funeral is discussed in much of the literature concerned with childhood bereavement. I found no endorsement of coerced child attendance at funerals. In fact, a general trend to exclude children under the age of five was present. (LeShan, 1976; Furman, 1974) Kavanagh (1972) feels that

the parents' emotional tone at a funeral far outweighs the importance of what a child sees or hears. Through honest telling and sharing, Kavanagh feels parents give permission to the child to be genuine and real with their feelings; to feel what they feel without fear or shame. It is this type of atmosphere that normal bereavement can be expressed and disturbance avoided.

With the death of a parent, Furman (1970) stresses the fulfullment of needs that must be met for children. She discusses the strong need for consistency in care giving and the unchanged maintenance of his or her environment. Furman cautions against future emotional problems resulting from too much physical moving and too many different individuals providing care at this time. In the case of an expected death of a mother, Furman suggests a gradual transferring of care to the mother substitute while the mother is still alive to ensure both mother and child that needs will be met.

After the death of a parent, Furman feels that a child needs and wants to remember the parent, but might find this difficult to do over time. She suggests photographs and verbal reminders be a part of the child's life provided by his or her other parent or guardian. Furman further points out the continued significance of parental loss. It is not a one time loss that is experienced and resolved, but at many times, especially times of life transitions, the loss is experienced anew and mourning is again felt.

Shen a child is fatally ill, many researchers feel the child knows death is

imminent (Morrissey, 1963, 1964; Kavanagh, 1972; Wiener, 1970; Schowalter, 1970), and yet journals advise doctors and family to avoid this topic (Howell, 1966; Evans, 1968) or report that avoidance is a common reaction (Schowalter, 1970; Wiener, 1970). The question has to be asked: "Who are we sparing?" and "At what cost to the child?"

Kavanagh (1972) speaks directly to this issue in the following quote: "Either the child shares what he knows about dying, or his final days are a lonely vigil, a sentence of fear and guilt, confinement and confusion." (p. 142).

DERIVED COMPETENCIES AND STRENGTHS OF CHILDHOOD BEREAVEMENT

Hilgard, Newman and Fish (1959) discuss case studies of well adjusted women who have lost their fathers during their childhood. The authors identified significant factors that they felt facilitated a normal development following the paternal death. The mothers in these case histories kept the home intact while serving both as breadwinner and homemaker. The majority of these mothers were characterized as strong, pioneer types who met hardships with courage. The traits of courage were much more pronounced than traits of warmth or tenderness. The mothers maintained a network of support outside of the home and made use of it when needed. For some women this included relatives, church and community agencies. Also important in these case studies was evidence of complete and immediate mourning following the father's death.

The dearth of research substantiating normal development following a childhood experience with death may only reflect a tendency to report and record abnormalities. It is difficult to assess the pervasiveness of normal development following childhood bereavement because of this bias. Such children or adults are not seen in thereapy as often as those who experience emotional disturbance as a result of the same experience.

Perhaps we all pay a price for emotional growth. Whether it is the end of innocence or the beginning of self-reliance, death affects us all. It is the brutalizing effect of childhood experiences that we wish to avoid while at the same time allowing the phoenix to arise from the ashes. In O'Gorman's book, The Storefront (1970), the relationship of childhood trauma to adult development is succintly expressed:

> Childhood is a gift the gods give children. It is as precious as the rubies they give the earth and the sun they give the spheres. It is each child's absolutely; as rare as a unicorn or a phoenix. One childhood to every child. No two childhoods alike. Childhood is the form that upholds each child's life forever. If a man or a society taints a child's childhood, brutalizes it, strikes it down, and corrupts it with fear and bad dreams, then he maims that child forever, and the judgment on that man and that society will be terrible and eternal. (p. 3)

Without the power, ability or even the desire to eliminate paint, we can help children to grow from a traumatic experience. There is something to be gained from living in the shadows of life at times. With intervention and integrative assistance, a death experience can be an eventual reservoir from which one draws sensitivity, strength and self reliance.

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